

R590. Insurance, Administration.

R590-148. Long-Term Care Insurance Rule.

R590-148-1. Authority.

This rule is issued pursuant to the authority vested in the commissioner under Sections 31A-2-201 and 31A-22-1404.

R590-148-2. Purpose.

The purpose of this rule is to implement standards for full and fair disclosure of the manner, content, and required disclosures for long-term care insurance to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

R590-148-3. Applicability and Scope.

Except as otherwise specifically provided, this rule applies to all long-term care insurance, as defined in 31A-1-301, delivered or issued for delivery in this state on or after January 1, 1993, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

R590-148-4. Incorporation by Reference.

The following tables and appendices are hereby incorporated by reference within this rule and are available for public inspection at the Insurance Department during normal business hours or at <http://www.insurance.utah.gov/ruleindex.html>. These tables and appendices were adopted by the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulation #641, as approved April 2000.

(1) Table I, Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance.

(2) Table II, Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance.

(3) Table III, Triggers for a Substantial Premium Increase.

(4) Table IV, Long-Term Care Insurance Outline of Coverage.

(5) Appendix A, Rescission Reporting Form.

(6) Appendix B, Long-Term Care Insurance Personal Worksheet.

(7) Appendix C, Things You Should Know Before You Buy Long-Term Care Insurance.

(8) Appendix D, Long-Term Care Insurance Suitability Letter.

(9) Appendix E, Claims Denial Reporting Form Long-Term Care Insurance.

(10) Appendix F, Worksheet Potential Rate Increase Disclosure Form.

(11) Appendix G, Replacement and Lapse Reporting Form.

R590-148-5. Definitions.

(1) For the purpose of this rule, the terms "applicant," "long-term care insurance," "certificate," "commissioner," and "policy" shall have the meanings set forth in Sections 31A-1-301 and 31A-22-1402.

(2) In addition, the following definitions apply:

(a) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(b) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

(c) "Adult day care" means a program for three or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or disabled adults who can benefit from care in a group setting outside the home.

(d) "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

(e) "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(f) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

(g)(i) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(A) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

(h) "Dressing" means putting on and taking off all items of

clothing and any necessary braces, fasteners or artificial limbs.

(i) "Eating" means feeding oneself by getting food into the body from a receptacle, such as a plate, cup or table, or by a feeding tube or intravenously.

(j)(i) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:

(A) due to changes in laws and rules applicable to long-term care coverage in this state; or

(B) due to increased and unexpected utilization that affects the majority of insurers of similar products.

(ii) Except as provided in Section R590-148-24, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(iii) The commissioner may request review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(iv) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(k) "Hands-on assistance" means physical assistance, minimal, moderate or maximal, without which the individual would not be able to perform the activity of daily living.

(l) "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(m) "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

(n) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(o) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

(p) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(q) "Mental or nervous disorder" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

(r) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living, for example bathing, eating, dressing, transferring and toileting.

(s) "Qualified actuary" means a member in good standing of

the American Academy of Actuaries.

(t) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(u) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows:

- (i) institutional long-term care benefits only;
- (ii) non-institutional long-term care benefits only; or
- (iii) comprehensive long-term care benefits.

(v) "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(w) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(x) "Transferring" means moving into or out of a bed, chair or wheelchair.

(3) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

R590-148-6. Required Provisions and Practices.

(1) Renewability.

The terms "guaranteed renewable" and "noncancellable" may not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Subsection R590-148-6(1)(b).

(a) No policy issued to an individual may contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(i) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(ii) The term "noncancellable" may be used only when the

insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(b) Individual long-term care insurance policies shall contain a renewability provision. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision may not apply to policies which do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.

(c) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and Exclusions.

(a) No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

- (i) preexisting conditions or diseases;
- (ii) mental or nervous disorders; however, this may not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease, or any other mental or nervous disorder of organic origin;
- (iii) alcoholism and drug addiction;
- (iv) illness, treatment or medical condition arising out of:
 - (A) war or act of war, whether declared or undeclared;
 - (B) participation in a felony, riot or insurrection;
 - (C) service in the armed forces or auxiliary units;
 - (D) suicide, sane or insane, attempted suicide or intentionally self-inflicted injury; or
 - (E) aviation for non-fare-paying passengers;
- (v) treatment provided in a government facility, unless otherwise required by law,
- (vi) services for which benefits are paid under:
 - (A) Medicare or other governmental program, except Medicaid;
 - (B) any state or federal workers' compensation;
 - (C) employer's liability or occupational disease law; or
 - (D) any motor vehicle no-fault law;
- (vii) services provided by a member of the covered person's immediate family;
- (viii) services for which no charge is normally made in the absence of insurance;
- (ix) benefits provided for a level of care cannot be conditioned on a requirement that the care be in a facility licensed for higher levels of care.

(b) Subsection R590-148-6(2)(a) is not intended to prohibit exclusions and limitations by type of provider or territorial limitations outside the United States.

(3) Preexisting Condition Limitation. If a long-term care insurance policy or certificate contains any limitations with

respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(4) Benefit Triggers. Activities of daily living and cognitive impairment may be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(5) Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(6) Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(a) may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) may not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(7) Premiums.

(a) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

(c) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section R590-148-14, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(d) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section R590-148-14, the initial annual premium shall be based on the reduced benefits.

(8) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care

insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, this premium charge shall be set forth in the policy, rider or endorsement.

(9) Payment of Benefits. A long-term care insurance policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

(10) Eligibility for Benefits Limitations and Conditions. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 31A-22-1407 shall set forth a description of these limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."

(11) Disclosure of Tax Consequences. With regard to life insurance policies which provide for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the benefit payment request is submitted that receipt of these benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

(12) Qualified Contracts. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(13) Nonqualified Contracts. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

(14) Long-term care insurance sold in conjunction with another insurance product, including but not limited to life insurance or annuities shall be in the form of a separate rider complying with all provisions of this Rule. Long-term care insurance shall not be incorporated into a life insurance policy or annuity contract.

R590-148-7. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies.

(1) A long-term care insurance policy or certificate shall

not, if it provides benefits for home health care services, limit or exclude benefits:

(a) by requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;

(b) by requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(c) by limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the aid or worker's licensure or certification;

(e) by excluding coverage for personal care services provided by a home health aide;

(f) by requiring that the provision of home health care services be at a level of certification or licensure greater than that required for the eligible service;

(g) by requiring that the insured have an acute condition before home health care services are covered;

(h) by limiting benefits to services provided by Medicare-certified agencies or providers; or

(i) by excluding coverage for adult day care services.

(2) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(3) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement may not apply to policies or certificates issued to residents of continuing care retirement communities.

R590-148-8. Standards for Benefit Triggers.

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the activities of daily living or the presence of cognitive impairment.

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection R590-148-5(2)(a) as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections R590-

148-8(1) and (2).

(4) For purposes of this section the determination of a deficiency shall not be more restrictive than:

(a) requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(b) if the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(7) The requirements set forth in this section shall be effective January 1, 2003 and shall apply as follows:

(a) Except as provided in Subsection R590-148-8(7)(b), the provisions of this section apply to a long-term care policy issued in this state on or after July 1, 2002.

(b) For certificates issued on or after July 1, 2002, under a group long-term care insurance policy that was in force at the time this rule became effective, the provisions of this section shall not apply.

R590-148-9. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts.

(1) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

(3) Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection R590-148-9(2) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

(4) Certifications required pursuant to Subsection R590-148-9(2) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

(5) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

R590-148-10. Continuation and Conversion.

(1) Group long-term care insurance issued in this state on or after July 1, 2002 shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section:

(a) "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers, facilities, or both, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and any group policy which it replaced, for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(c) "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers, facilities, or both, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.

(d) a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(3) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 60 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(4) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted

policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(5) The premium for the individual converted policy shall not exceed the insurer's customary rate at the time of the termination, which is applicable to the form and amount of the individual policy, and to the class of risk to which the person belonged when terminated from the group policy.

(6) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) the terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(i) providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) the premium for which is calculated in a manner consistent with the requirements of Subsection R590-148-10(4).

(7) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. This provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(8) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, may not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(9) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

R590-148-11. Unintentional Lapse and Reinstatement.

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1)(a) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant,

who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

(b) The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

(c) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan the requirements contained in Subsection R590-148-11(1)(a) need not be met until 60 days after the policyholder or certificateholder is no longer on a payroll or pension deduction plan.

(d) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection R590-148-11(1)(a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirement in Subsection R590-148-11(1)(a), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

R590-148-12. Applications, Enrollment and Replacement of

Coverage.

(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)(a) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(b) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate may not be rescinded for that condition.

(3) All applications shall clearly indicate the payment plan selected by the applicant.

(4) Except for policies or certificates which are guaranteed issue:

(a) the following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.

(b) the following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance (policy) (certificate) was based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address)

(5) Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

- (a) a report of a physical examination;
- (b) an assessment of functional capacity;
- (c) an attending physician's statement; or
- (d) copies of medical records.

(6) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(7) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term

care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing these questions may be used. With regard to a replacement policy issued to a group, other than employee and labor union groups, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

(a) Do you have another long-term care insurance policy or certificate in force, including health care service contract, health maintenance organization contract?

(b) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(c) Are you covered by Medicaid?

(d) Do you intend to replace any of your medical or health insurance coverage with this policy/certificate?

(8) Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

(b) List policies sold in the past five years which are no longer in force.

(9) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of this notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the manner detailed in Table I, Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance.

(10) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the manner detailed in Table II, Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance.

(11) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. The notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(12) Life insurance policies and certificates that provide benefits for long-term care shall comply with this section if the

policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of R590-93, Replacement of Life Insurance and Annuities. If a life insurance policy that provide benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

(13) Electronic Enrollment for Group Policies:

(a) In the case of a group policy, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(i) the consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(ii) the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(iii) the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the confidentiality of individually identifiable information and "privileged information" as defined by the Utah Government Records Access and Management Act, Section 63-2-101, is maintained.

(b) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

R590-148-13. Requirement to Offer Inflation Protection.

(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%;

(b) guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The premium rate for the additional benefit shall not exceed the insurer's customary rate at the time the offer is made, which is applicable to the form and amount of the policy, the class of risk to which the person belonged at the time of issue of the policy, and to the age attained on the effective date of the increase. The amount of the additional benefit may be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the policy is issued to a group, except a continuing care retirement community center, the required offer in Subsection R590-148-13(1) shall be made to the group policyholder and to each proposed certificateholder.

(3) Insurers shall include the following information in or with the outline of coverage:

(a) a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20 year period; and

(b) any expected premium increases or additional premiums to pay for automatic or optional benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(4) Inflation protection benefit increases under a policy which contains this benefit shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(5) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(6)(a) Inflation protection as provided in Subsection R590-148-13(1)(a) shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

(b) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans (indicate), and I reject inflation protection.

R590-148-14. Nonforfeiture and Contingent Benefit Requirements.

(1) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 31A-22-1412:

(a) a policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection R590-148-14(4); and

(b) the offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

(2) If the offer required to be made under Section 31A-22-1412 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(3)(a) After rejection of the offer required under Section 31A-22-1412, for individual and group policies without nonforfeiture benefits issued after July 1, 2002, the insurer shall provide a contingent benefit upon lapse.

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Table III, Triggers for a Substantial Premium Increase, based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

(d) On or before the effective date of a substantial premium increase as defined in Subsection R590-148-14(3)(c), the insurer shall:

(i) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection R590-148-14(4). This option may be elected at any time during the 120-day period referenced in Subsection R590-148-14(3)(c); and

(iii) notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection R590-148-14(3)(c) shall be deemed to be the election of the offer to convert in Subsection R590-148-14(3)(d)(ii).

(4) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(a) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

(b) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits, amounts and frequency in effect at the time of lapse but not increased thereafter, will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Subsection R590-148-14(4)(c).

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the

nonforfeiture credit is subject to the limitation of Subsection R590-148-14(5).

(d)(i) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(ii) Notwithstanding Subsection R590-148-14(4)(d)(i), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) the end of the tenth year following the policy or certificate issue date; or

(B) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(5) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits, which would be payable if the policy or certificate had remained in premium paying status.

(6) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(7) The requirements set forth in this section shall become effective January 1, 2003 and shall apply as follows:

(a) Except as provided in Subsection R590-148-14(7)(b), the provisions of this section apply to any long-term care policy issued in this state on or after July 1, 2002.

(b) For certificates issued on or after July 1, 2002, under a group long-term care insurance policy, which policy was in force at the time this rule became effective, the provisions of this section shall not apply.

(8) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section R590-148-22 treating the policy as a whole.

(9) To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection R590-148-14(3)(c), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(10) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(a) the nonforfeiture provision shall be appropriately captioned;

(b) the nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in

changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(c) the nonforfeiture provision shall provide at least one of the following:

- (i) reduced paid-up insurance;
- (ii) extended term insurance;
- (iii) shortened benefit period; or
- (iv) other similar offerings approved by the commissioner.

R590-148-15. Standard Format Outline of Coverage.

This section of the rule implements, interprets and prescribes a standard format of an outline of coverage for the provisions in Subsection 31A-22-1409(2).

(1) The outline of coverage shall be a free-standing document, using no smaller than ten point type.

(2) The outline of coverage may contain no material of an advertising nature.

(3) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) The format for outline of coverage can be found in Table IV, Long-Term Care Insurance Outline of Coverage.

R590-148-16. Requirement to Deliver Shopper's Guide.

(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders that provide long-term care benefits are not required to furnish the above-referenced guide if the long term care benefits are incidental, but shall furnish the policy summary required under Subsection 31A-22-1409(8).

R590-148-17. Suitability.

(1) Every insurer shall:

(a) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) train its agents in the use of its suitability standards; and

(c) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(2)(a) To determine whether the applicant meets the standards

developed by the insurer, the agent and insurer shall develop procedures that take the following into consideration:

(i) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(iii) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The insurer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Subsection R590-148-17(2)(a). The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12 point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the insurer's personal worksheet shall be filed with the commissioner.

(c) A completed personal worksheet shall be returned to the insurer prior to the insurer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(d) The sale or dissemination outside the company or agency by the insurer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

(3) The insurer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(4) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(5) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C in not less than 12 point type.

(6) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application. In the alternative, the insurer shall send the applicant a letter similar to Appendix D, Long-Term Care Insurance Suitability Letter. However, if the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(7) If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-

term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

R590-148-18. Marketing Standards.

(1) Every insurer shall:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(d) Provide copies of the disclosure forms required in Subsection R590-148-19(2) to the applicant. See Appendix B, Long-Term Care Insurance Personal Worksheet, and Appendix F, Potential Rate Increase Disclosure Form.

(e) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of this insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

(f) Every insurer or entity marketing long-term care insurance shall establish audit able procedures for verifying compliance with this Subsection R590-148-18(1).

(g) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

(h) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsections R590-148-6(1)(a)(ii) and R590-148-6(6)(a).

(i) Provide an explanation of contingent benefit upon lapse provided for in Subsection R590-148-14(3)(c).

(2) In addition to the practices prohibited in Part 3, Chapter 23 of Title 31A, the following acts and practices are prohibited:

(a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(b) High pressure tactics. Employing any method of marketing

having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

R590-148-19. Required Disclosure of Rating Practices to Consumer.

(1) This section shall apply as follows:

(a) Except as provided in Subsection R590-148-19(1)(b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2003.

(b) For certificates issued on or after July 1, 2002, under a group long-term care insurance policy, which policy was in force at the time this rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2003.

(2) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

(a) A statement that the policy may be subject to rate increases in the future;

(b) an explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(c) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) a general explanation for applying premium rate or rate schedule adjustments that shall include:

(i) a description of when premium rate or rate schedule adjustments will be effective, e.g., next anniversary date, next billing date, etc.; and

(ii) the right to a revised premium rate or rate schedule as provided in Subsection R590-148-19(2)(b) if the premium rate or rate schedule is changed.

(e)(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) the policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount, percent, and date of implementation for each

increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(iii) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(iv) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the effective date of this section, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subsection R590-148-19(2)(e)(i).

(v) If the acquiring insurer in Subsection R590-148-19(2)(e)(iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subsection R590-148-19(2)(e)(iv), the acquiring insurer shall make all disclosures required by Subsection R590-148-19(2)(e), including disclosure of the earlier rate increase referenced in Subsection R590-148-19(2)(e)(iv).

(3) An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsections R590-148-19(2)(a) and (e). If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the forms in Appendix B, Personal Worksheet, and Appendix F, Potential Rate Increase Disclosure Form, to comply with the requirements of Subsections R590-148-19(1) and (2).

(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection R590-148-19(2) when the rate increase is implemented.

R590-148-20. Filing Requirements.

(1) Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 31A-22-1403, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or

regulatory long-term care insurance requirements substantially similar to those adopted in this state.

(2)(a) Every insurer shall provide a copy of any long-term care insurance advertisement intended for use in Utah whether through written, radio or television medium to the insurance commissioner of this state upon request.

(b) All advertisements shall be retained by the insurer, health care service plan or other entity for at least three years from the date the advertisement was first used.

(c) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

R590-148-21. Initial Filing Requirements.

(1) This section shall apply to any long-term care policy issued in this state on or after January 1, 2003.

(2) An insurer shall file the information listed in this subsection to the commissioner prior to making a long-term care insurance form available for sale:

(a) a copy of the disclosure documents required in Section R590-148-19; and

(b) an actuarial certification consisting of at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted; and

(D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(I) an aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

(II) if the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection R590-148-21(3) based on a

standard age distribution;

(v) (A) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(B) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(3) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(4) The premiums charged to an insured for long-term care insurance may not increase due to either:

(a) the increasing age of the insured at ages beyond 65; or

(b) the duration the insured has been covered under the policy.

R590-148-22. Loss Ratio.

(1) This section shall apply to all individual long-term care insurance except those covered in Sections R590-148-22 and R590-148-24.

(2) Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%, calculated in a manner which provides for adequate reserving of the long-term care insurance risk.

(3) In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) statistical credibility of incurred claims experience and earned premiums;

(b) the period for which rates are computed to provide coverage;

(c) experienced and projected trends;

(d) concentration of experience within early policy duration;

(e) expected claim fluctuation;

(f) experience refunds, adjustments or dividends;

(g) renewability features;

(h) all appropriate expense factors;

(i) interest;

(j) experimental nature of the coverage;

(k) policy reserves;

(l) mix of business by risk classification; and

(m) product features such as long elimination periods, high deductibles and high maximum limits.

(4) The premiums charged to an insured for long-term care insurance may not increase due to either:

(a) the increasing age of the insured at ages beyond 65; or

(b) the duration the insured has been covered under the policy.

(5) Rate filings documents must contain all information

required in R590-85-4.

R590-148-23. Reserve Standards.

(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves for these benefits shall be determined in accordance with Subsection 31A-17-504(7). Claim reserves must also be established when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event may the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (a) definition of insured events;
- (b) covered long-term care facilities;
- (c) existence of home convalescence care coverage;
- (d) definition of facilities;
- (e) existence or absence of barriers to eligibility;
- (f) premium waiver provision;
- (g) renewability;
- (h) ability to raise premiums;
- (i) marketing method;
- (j) underwriting procedures;
- (k) claims adjustment procedures;
- (l) waiting period;
- (m) maximum benefit
- (n) availability of eligible facilities;
- (o) margins in claim costs;
- (p) optional nature of benefit;
- (q) delay in eligibility for benefit;
- (r) inflation protection provisions; and
- (s) guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(2) When long-term care benefits are provided other than as in Subsection R590-148-23(1), reserves shall be determined in accordance with Minimum Reserve Standards for Individual and Group Health Insurance Contracts, Appendix A-010, Accounting Practices and Procedures Manual, edition March 2001, published by the National Association of Insurance Commissioners.

R590-148-24. Premium Rate Schedule Increases.

(1) This section shall apply as follows:

(a) except as provided in Subsection R590-148-24(1)(b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2003.

(b) for certificates issued on or after July 1, 2002, under a group long-term care insurance policy, which policy was in force at the time this rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2003.

(2) An insurer shall file notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner prior to the notice to the policyholders and shall include:

(a) information required by Section R590-148-19;

(b) certification by a qualified actuary that:

(i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(ii) the premium rate filing is in compliance with the provisions of this section;

(c) an actuarial memorandum justifying the rate schedule change request that includes:

(i) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale:

(A) annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(B) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections shall demonstrate compliance with Subsection R590-148-24(3); and

(D) for exceptional increases:

(I) the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) in the event the commissioner determines as provided in Section R590-148-5(2)(j)(iv) that offsets may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(iv) a statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) in the event that it is necessary to maintain consistent

premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(d) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(e) sufficient information for review of the premium rate schedule increase by the commissioner.

(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) exceptional increases shall provide that at least 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) the accumulated value of the initial earned premium times 58%;

(ii) 85% percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) the present value of future projected initial earned premiums times 58%; and

(iv) 85% percent of the present value of future projected premiums not in Subsection R590-148-24(3)(b)(iii) on an earned basis;

(c) in the event that a policy form has both exceptional and other increases, the values in Subsections R590-148-24(3)(b)(ii) and (iv) will also include 70% for exceptional rate increase amounts; and

(d) all present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves which is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract. The actuary shall disclose as part of the actuarial memorandum, the use of any appropriate averages.

(4) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in Subsection R590-148-24(2)(c)(i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection R590-148-24(11), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(5) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection R590-148-24(2)(c)(i), shall be filed for review by the commissioner every five years following the end of the required period in Subsection

R590-148-24(4). For group insurance policies that meet the conditions in Subsection R590-148-24(11), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(6)(a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection R590-148-24(3), the commissioner may require the insurer to implement any of the following:

- (i) premium rate schedule adjustments; or
- (ii) other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection R590-148-24(2)(c)(v), if applicable.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

- (a) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection R590-148-24(8); and

- (b) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection R590-148-24(3) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in Subsection R590-148-24(3)(a)(i) and (iii).

(8) (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- (i) the rate increase is not the first rate increase requested for the specific policy form or forms;

- (ii) the rate increase is not an exceptional increase; and

- (iii) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

- (i) The offer shall:
 - (A) be subject to the approval of the commissioner;
 - (B) be based on actuarially sound principles, but not be based on attained age; and
 - (C) provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- (ii) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 - (A) the maximum rate increase determined based on the combined experience; and
 - (B) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.
- (9) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection R590-148-24(8), prohibit the insurer from either of the following:
 - (a) filing and marketing comparable coverage for a period of up to five years; or
 - (b) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- (10) Subsections R590-148-24(1) through (9) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection R590-148-5(2)(m), if the policy complies with all of the following provisions:
 - (a) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 - (b) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
 - (i) Section 31A-22-408; and
 - (ii) Section 31A-22-409;
 - (c) the policy meets the disclosure requirements of Subsections 31A-22-1409(7) and (8) and 31A-22-1410;
 - (d) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
 - (i) policy illustrations as required by R590-177; and
 - (ii) disclosure requirements in R590-133;
 - (e) an actuarial memorandum is filed with the insurance department that includes:
 - (i) a description of the basis on which the long-term care rates were determined;
 - (ii) a description of the basis for the reserves;
 - (iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of

issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Subsections R590-148-24(6) and (8) shall not apply to group insurance policies where:

(a) the policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(b) the policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

R590-148-25. Reporting Requirements.

(1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(a) Every insurer shall report the 10% of its agents with the greatest percentages of lapses and replacements as measured by Subsection R590-148-25(1).

(b) Every insurer shall report the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(c) Every insurer shall report the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(d) The reports required by Subsection R590-148-25(1)(a), (b), and (c) must be reported on the "Replacement and Lapse Reporting Form," Appendix G.

(e) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more

closely agent activities regarding the sale of long-term care insurance.

(2) Every insurer shall report, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. The report used by the insurer shall contain, at a minimum, the information in the format contained in Appendix E, Claims Denial Reporting Form Long-Term Care Insurance, in not less than 12 point type.

(3) Every insurer shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually report this information in the format currently prescribed by the National Association of Insurance Commissioners.

(4) Every insurer shall report the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. The report must be submitted on the Suitability Reporting Form, Appendix H.

(5) For purposes of this section:

(a) "policy" shall mean only long-term care insurance;

(b) "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "denied" means that the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "report" means on a statewide basis.

(6) Reports required under this section shall be filed with the commissioner annually on or before June 30. All reports must be submitted in compliance with Rule R590-220-13, Submission of Accident and Health Insurance Filings: Additional Procedures for Long Term Products.

R590-148-26. Licensing.

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by Chapter 23 of Title 31A.

R590-148-27. Discretionary Powers of Commissioner.

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) the modification or suspension would be in the best interest of the insured; and

(2) the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3) one of the following occur:

(a) the modification or suspension is necessary to the

development of an innovative and reasonable approach for insuring long-term care;

(b) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of the community; or

(c) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

R590-148-28. Penalties.

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the rule of long-term care insurance or the marketing of this insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

R590-148-29. Enforcement Date.

Effective July 1, 2002, the department will enforce all sections of the rule that do not have a different compliance date.

R590-148-30. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this and the provisions of this rule are declared to be severable.

KEY: insurance

Date of Enactment or Last Substantive Amendment: July 30, 2007

Notice of Continuation: July 25, 2007

Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-22-1404